

Health Plan Enrollment or Change

for Vermont Group Plans



Action Requested: Enrollment Change Termination

Please complete both pages of this form.

To be Completed by Employer (please include the Group Name and Number on page 2)

Group Name	Group No.	Subgroup No.	Employee Class	Effective Date
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Section 1: Information About Yourself (please print)

Applicant Name (First, Middle Initial, Last) _____ Marital Status
 Single Married

Street Address _____ City _____ State _____ Zip Code _____

County _____ Home Phone No. _____ Mobile Phone No. _____

Email _____

Coverage Level Applicant Applicant and Spouse Applicant and Dependent(s) Family

Are you and/or your spouse eligible for Medicare? Yes No If Yes, provide your Medicare Member ID No(s).
 (Yourself) (Spouse, if eligible)

If Yes, provide Medicare Parts A and B Effective Dates.
 (Yourself) Part A _____ Part B _____ (Spouse) Part A _____ Part B _____

Section 2: Enrollment/Change/Termination Information

Enrollment or Change (check all that apply)

- New Applicant Add Dependent Name Change
 Transfer to Another Plan Address Change COBRA

Termination

- Terminate from Plan
 Remove Dependent(s) only (specify name or member ID no.)

Requested Effective Date

- Reason
- New Hire (Date of Hire: _____)
 Open Enrollment
 Qualifying Event (explain)

 Other _____

Requested Effective Date

Reason for Termination

- Termination of Employment Opting for Other Coverage
 Moved from Service Area
 Other _____

Section 3: Choose Your Coverage (Enrollments and Changes)

Standard Non-Standard Plan Name (e.g. Gold 4 HDHP) _____

Please note: Premium paid by employer group for Reflective plans is not eligible for the Small Business Health Care Tax Credit.

If scanning this form, be sure to scan both sides.

Continued on page 2.

Group Name	Group No.	Applicant Name
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Section 4: Information About All Family Members You Want to Enroll in Your Plan (Enrollments and Changes)

Please use a separate form for additional individuals.

1 Applicant	<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of Birth <i>(required)</i>	Social Security No. <i>(required)</i>
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2 Name <i>(First, Middle Initial, Last)</i>	Relationship to Applicant
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
Age	Date of Birth <i>(required)</i>
Social Security No. <i>(required)</i>	

3 Name <i>(First, Middle Initial, Last)</i>	Relationship to Applicant
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Dependent
Age	Date of Birth <i>(required)</i>
Social Security No. <i>(required)</i>	

4 Name <i>(First, Middle Initial, Last)</i>	Relationship to Applicant
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Dependent
Age	Date of Birth <i>(required)</i>
Social Security No. <i>(required)</i>	

Section 5: Authorization (Your Signature is Required for Enrollments, Changes, or Terminations)

On behalf of myself and any members of my family for whom I have enrollment authority and have listed on this enrollment form, I (we) hereby apply for membership in MVP. I hereby consent to the release, use, and disclosure of any medical information about me and any members of my family for whom I can give consent:

- By my primary care provider, any other health care provider, or applicable Vermont regulatory agency to MVP and any health care providers involved in caring for me or my family, as reasonably necessary for MVP or my health care providers to carry out treatment, payment, or health care operations functions, or other functions permitted by, and in accordance with, applicable laws, regulations, and rules. This may include pharmacy and other medical claims information needed to help manage my care;
- By MVP and any health care providers to applicable Vermont regulatory agency and other authorized federal, state, and local agencies for purposes of administering health programs to the extent permitted by, and in accordance with, applicable laws, regulations, and rules; and
- By MVP to my providers or other persons or organizations, as reasonably necessary for MVP or my providers to carry out treatment, payment, or health care operations, or as otherwise and to the extent permitted by, and in accordance with, applicable laws, regulations, and rules.

I also agree that the information released for treatment, payment, and health care operations may include information about me concerning HIV and/or mental health, to the extent permitted by applicable laws, until I revoke this consent.

At any time, I can take away the permission I gave to release information. All I have to do is call the MVP Customer Care Center at the phone number listed on the back of my MVP Member ID card.

I hereby certify that the statements made are true and complete to the best of my knowledge and belief.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to a civil penalty.



Unless otherwise prohibited by law, I consent to the receipt of electronic communications related to my MVP health plan at the email address I provided. I understand that I am entitled to receive paper documents, and that I can set and change my communication preferences at any time by signing in at **mvphealthcare.com** and selecting *Communication Preferences*. I have read and agree to the details outlined in MVP's *Electronic Disclosure*, which is available at **mvphealthcare.com** or by calling MVP at **1-800-TALK-MVP** (825-5687).

I have read and agree to this authorization.

Signature

Date

Please return all pages of the completed form by mail to: **MVP HEALTH CARE 625 STATE ST SCHENECTADY NY 12305-2111**

Questions? We're here to help.  Call **1-844-865-0250**  Or visit **mvphealthcare.com**